



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

RENAISSANCE HOSPITAL  
C/O BURTON & HYDE PLLC  
PO BOX 684749  
AUSTIN TX 78768-4749

#### **Respondent Name**

HARTFORD UNDERWRITERS INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 47

#### **MFDR Tracking Number**

M4-05-B620-01

#### **MFDR Date Received**

August 19, 2005

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Payments according to the average amount paid system-wide for all workers' compensation hospital outpatient admissions in the State of Texas with the same Principal Diagnosis Code, Principal Procedure Code, and admission year is a fair and reasonable reimbursement."

**Amount in Dispute:** \$6,231.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "It is the Respondents position that the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the **ACT**. Specifically, the amount paid by the Respondent was more than that which would be allowed under Medicare. Respondent has paid Requestor \$1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization. . . . As the Requestor, the health care provider has the **burden to proof** [sic] that the fees paid were not fair and reasonable. . . . In summary the Requestor was paid more than a **fair and reasonable** amount as determined in accordance with the criteria for payment under the **ACT** and is not entitled to additional reimbursement from Hartford Insurance Co."

**Response Submitted by:** The Hartford, 300 S. State St., Syracuse, New York 13202

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 30, 2004	Outpatient Services	\$6,231.00	\$825.43

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes

2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on August 19, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 30, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. By letter dated July 5, 2013, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – HOUSTON)* that specified, in pertinent parts, an "Additional Reimbursement Amount Owed" of \$825.43. The Division notes that the amount in dispute of \$6,231.00 specified above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - M – IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AS FAIR AND REASONABLE.

## **Findings**

1. This dispute relates to outpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
  - The requestor's amended position statement asserts that "Payments according to the average amount paid system-wide for all workers' compensation hospital outpatient admissions in the State of Texas with the same Principal Diagnosis Code, Principal Procedure Code, and admission year is a fair and reasonable reimbursement."
  - In support of the requested reimbursement methodology the requestor states that "Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment. . . . creates an expectation of fair reimbursement; and . . . encourages health care providers to continue to offer quality medical care to injured employees. . . . ensures that similar procedures provided in similar circumstances receive similar reimbursement. . . . The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division."
  - The Division notes that it has utilized similar data to determine "fair and reasonable" fee guidelines. See, for example, the adoption preamble to the *Hospital Facility Fee Guideline—Outpatient* at 28 Texas Administrative Code §134.403, 33 *Texas Register* 400-407, which specified, in pertinent parts, that:  
 In maintaining a medical billing database, the Division requires carriers to submit billing and reimbursement information to the Division on a regular basis . . . The Division provided Milliman with the 837 data set for CY 2005, which included information on approximately 12,000 inpatient billing lines and 166,000 hospital outpatient billing lines . . . Milliman estimated that CY 2005 Texas workers' compensation outpatient facility reimbursement represented approximately 186 percent of Medicare

allowable levels for outpatient services . . . The Division considered the issues of medical cost containment as prescribed by Labor Code §413.011 . . . Research conducted by the Workers' Compensation Research Institute concludes that... hospital outpatient payments per claim in Texas were lower than the 13-state median studied . . . Based on all of these factors . . . The Division adopts PAFs of 200 percent and 130 percent of Medicare reimbursement for use in determining Texas workers' compensation outpatient facility service reimbursement.

- The requestor further asserts that “The Division has adopted the Petitioner’s methodology in at least 114 medical fee dispute decisions to date,” and gives citations for the Division medical fee dispute resolution findings and decisions supporting the requestor’s methodology.
- The requestor submitted documentation to support the state-wide, annual, average reimbursement in Texas for the principal diagnosis code and principal procedure code of the disputed services during the year that the services were rendered.
- The requestor has explained and supported that the requested reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that the average amount paid by all insurance carriers in the Texas workers’ compensation system in the same year as the disputed admission for those admissions involving the same principal diagnosis code and principal procedure code is a fair and reasonable rate of reimbursement for the services in dispute.

4. 28 Texas Administrative Code §133.307(j)(1)(A), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response, unless previously provided in the request and requestor's additional documentation, shall include “documentation of carrier response to reconsideration in accordance with commission rules.” Review of the submitted documentation finds that the respondent has not provided documentation of carrier response to reconsideration in accordance with commission rules. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(A).
5. 28 Texas Administrative Code §133.307(j)(1)(F), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include “if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011 and §§133.1 and 134.1 of this title.” Review of the submitted documentation finds that:
  - The respondent’s position statement asserts that “It is the Respondents position that the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the ACT.”
  - The respondent did not submit documentation to support that “the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the **ACT**.”
  - The respondent’s position statement asserts that “the amount paid by the Respondent was more than that which would be allowed under Medicare.”
  - The respondent states that “studies show that Medicare patients are of an equivalent standard of living to workers’ compensation patients.”
  - The respondent did not submit copies of the referenced studies for review.
  - The respondent did not submit documentation to support that “the amount paid by the Respondent was more than that which would be allowed under Medicare.”
  - The respondent did not submit documentation to support how paying an amount more than that which would be allowed under Medicare would provide for a fair and reasonable reimbursement for the services in this dispute.
  - The respondent’s position statement asserts that “Respondent has paid Requestor \$1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization.”
  - The Division notes that the per diem reimbursement for a surgical admission under the Division’s former *Acute Care Inpatient Hospital Fee Guideline* is not applicable to the outpatient services in this dispute. Per former 28 Texas Administrative Code §134.401(a)(4) “Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements.”
  - The respondent did not describe or address the specific services provided to the injured worker.
  - The respondent did not explain how the services in dispute are comparable to the facility charges associated with a spinal surgery and a one-day inpatient hospitalization.
  - The respondent did not discuss or explain how the amount paid represents a fair and reasonable reimbursement for the services in dispute.

- The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement for the disputed services.
- The respondent did not explain how the amount paid satisfies the requirements of 28 Texas Administrative Code §134.1.

The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(j)(1)(F).

6. The Division finds that the documentation submitted in support of the fair and reasonable methodology proposed by the requestor based on the average amount paid by all insurance carriers in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute is the best evidence in this dispute of an amount that will achieve a fair and reasonable reimbursement for the services in this dispute. Reimbursement will therefore be calculated as follows. Review of the medical bill finds that the principal diagnosis code for the disputed services is 724.4. The principal procedure code is 03.91. The requestor submitted documentation to support that the average, state-wide reimbursement for this diagnosis code and procedure code performed in 2004 was \$1,943.43. This amount less the amount previously paid by the respondent of \$1,118.00 leaves an amount due to the requestor of \$825.43. This amount is recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established that additional reimbursement is due. The Division concludes that the carrier's response was not submitted in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the respondent failed to support that the amount paid by the insurance carrier is a fair and reasonable reimbursement in accordance with Division rule at 28 Texas Administrative Code §134.1. As a result, the amount ordered is \$825.43.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$825.43 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	October 9, 2013 Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**